Rationale Provided by Medical Establishment for Segregation and Protection of Residency Positions for Graduates of Canadian and American Medical Schools

Acronyms/Definitions:

IMG: "International Medical Graduate". A graduate of a medical school outside of Canada or the United States.
CMG: "Canadian/American Medical Graduate". A graduate of a medical school in Canada or the United States.

Introduction

The effect of limiting the number of residency training jobs and prohibiting Canadian citizens and permanent residents who graduated from international medical schools and proved substantial equivalency from competing for 90% of these jobs is:

a. To ensure that even the weakest graduates of Canadian and American medical school become licensed;
b. To exclude the majority of Canadians who are international graduates from becoming licensed to practice medicine in Canada thus depriving most immigrant physicians from being able to practice their professions;
c. To restrict Canadians who are international graduates to a few residency jobs mostly in underserviced disciplines and underserviced regions;
d. To deem Canadians who are international graduates from equal participation in the benefits and opportunity Canada has to offer;
e. To deprive the diverse sector of new Canadians from physicians who share their language and their culture.

So how does a government that espouses freedom, equality, and inclusion justify a system which clearly makes Canadians who are international medical graduates into second class citizens?

Medical Establishment Rationale for Systemic Discrimination and Flaws of the Rationale

1. Taxpayer investment in graduates of Canadian medical schools requires that Canadian medical school graduates be provided with residency positions so they can progress to full licensure.

   But the scheme is inconsistent with this rationale.

   - This argument is fundamentally flawed. Governments do not invest in individuals; they invest in education. Taxpayers invest in high school education. This does not entitle all high school graduates to enter university. Taxpayers invest in undergraduate programs but this does not ensure that the individuals who obtained Bachelors' degrees can progress to higher level education or government

funded jobs they are educated for and aspire to. Taxpayers invest in numerous professional degrees. Yet no government sets out to ensure that all these professional degree holders obtain postgraduate training positions necessary to become licensed to practice the profession. In each instance but medicine, at each stage, the next step of advancement involves allowing all those that are qualified to apply with selection based on the individual's attributes relevant to the next level.

- It is a fundamental principle of justice that advancement to the next stage of education/professional training is to be based on individual merit relevant to the position sought. This is fundamental to every Canadians' sense of fairness. This principle is also enshrined in the United Nations Declaration of Human Rights to which Canada is a signatory.
- Education is within provincial jurisdiction and paid by taxpayers of an individual province. The investment argument is inconsistent with the fact that the system provides that graduates from all Canadian and American medical schools have access to a stream where there are more positions than applicants, but taxpayers have only invested in the education of the students in their own province, nowhere else. Further, there are Canadians who have chosen to study at international medical schools who have received provincial and Canada student grants and loans, and yet despite this investment in them by the province and the nation, they have very limited access to residency training and hence becoming licensed in the medical profession.
- If the scheme was based on return on investment, there would be reciprocal obligations between investor and student. There is not. In fact, graduates of medical schools are not particularly loyal to the provincial taxpayers that subsidized their education. For instance, in 2020 only 57% of UBC medical graduates stayed in BC, 61% of medical graduates of Alberta universities stayed in Alberta, 56% of Saskatchewan medical graduates stayed in Saskatchewan, and 62% of Manitoba graduates stayed in Manitoba. No province keeps all its medical school graduates because there is no contract with individuals. Some Canadian medical school graduates leave Canada to work elsewhere--some right after graduating medical school and others immediately after completing residency training.
- Regardless, this type of rationale is illogical at its foundation. This rationale is called the Sunk Cost Fallacy in the fields of Economics and Psychology and is taught in every school of business or economics in Canada. Further investment in a previous less productive investment does not maximize returns. Good business and good governance require evaluation of all investment options, and redirection of resources to the most likely to succeed. Since entry to medical school, some students will have thrived and proven themselves competent in their knowledge and skills and well suited to the demands of medicine, while some will have failed to do so. Quality of care and costs associated with efficiency/inefficiency, best practice/incompetence, and accuracy/error determines productivity and strength of the health care system. Sound investment strategy and the public interest requires hiring of resident physicians after objective evaluation and fair competition on the basis of a particular individual's demonstrated merit.
- If the selection of doctors of tomorrow is to be made on the basis of financial consideration, there are cost savings to government in increasing IMGs specifically.

A University of Calgary Economics report concluded "for the same resources needed to train 1 medical student to enter residency, the Alberta IMG program identified 10 'residency-ready' IMGs. The rate of return to Albertans from licensing an IMG to practice as a family physician was between 9% and 13% which is clearly a desirable and socially accountable use of public resources" https://www.semanticscholar.org/paper/Social-rates-of-return-to-investment-in-skills-and-Emery-Crutcher/9207dcf2a0c175142abbe05ed2ae6793efaeb0a1

2. Accreditation and public safety. Graduates from medical schools accredited by the LCME and CACM are treated differently from those who do not come from accredited schools for the purpose of ensuring public safety.
    - Medical schools are generally accredited by national organizations. In medicine the World Federation for Medical Education (WFME) was established as the global organization dedicated to the improvement of health of all people through the creation of a transparent and rigourous method of ensuring that accreditation of medical schools, world-wide, is always at an internationally accepted and high standard." The WFME created the World Directory of Medical Schools which lists medical schools that have been accredited by national medical accrediting agencies which have been reviewed by the WFME.
    - The LCME and the CACM, the accrediting agencies in the USA and Canada, have been reviewed by the WFME to ensure their accreditation methods meet the WFME standards.
    - It is for the medical regulatory authority of each province to regulate for public safety. They all have. All Colleges recognize medical degrees on the WFME's World Directory of Medical Schools, as does the immigration arm of the federal government. For some provinces, a degree on this Directory is sufficient to address the educational requirement to work as a resident physician. If it is not, additional assessments or examinations are mandated by the College to ensure public safety.
    - Accreditation is not intended to be a barrier. Methods have been developed to determine whether international graduates meet the Canadians standard. In medicine this is accomplished through Medical Council of Canada examinations (MCCQE1 and NAC OSCE) designed to determine whether or not one has the critical medical knowledge, decision-making ability, and clinical skills expected of a graduate of a Canadian medical school ready to enter residency training.
    - Before these examinations were developed lack of accreditation could fairly be held out as a legitimate barrier. **But not anymore**.
    - Today it is clear that the purpose of the exclusion of Canadians who graduated from international schools is to protect graduates of Canadian medical schools from Canadians who if allowed to compete on the basis of individual merit, would displace the weaker graduates of Canadian medical schools. This nepotism on the part of Faculties of Medicine of Canada has developed to a place where it risks compromising public safety. Canadian and American medical schools in recent times have developed a policy against failing students. This has resulted in 3-5% of

graduates of Canadian medical schools failing the MCCQE1 which is the exam designed to determine whether one has the critical medical knowledge and decision-making ability expected of a graduate of a medical graduate.

- Inherent in the current system is a double standard. Public safety is more likely to be compromised by weak graduates of Canadian and American medical schools. The policy of these schools is to mark pass/fail, to support weak candidates, and not to fail students. These graduates are never required to take the NAC OSCE. They do take the MCCQE1 at the end of medical school but the system allows them, despite failure of this critical medical knowledge exam, to work as resident physicians. Resident physicians always work long hours providing necessary medical services to the public, and sometimes make life and death decisions. By contrast, the system is robust in ensuring that Canadians who have medical degrees from international medical schools have the knowledge and skills necessary to practice safely. They can only apply after passing the NAC OSCE and MCCQE1. In reality, they must not just pass these exams and other provincial assessments, they must excel to have any chance of getting a residency position.
- In the context of public safety, it is important to distinguish between graduates of international medical schools who are citizens and permanent residents of Canada versus foreigners who work as resident physicians under a work visa. As described above, Canadians must meet a robust standard, but non-Canadians who are international medical graduates are not subject to the same standards. In some provinces, like British Columbia these non-Canadians do not have to pass the NAC OSCE, the MCCQE1, nor a provincial assessment called the CAP to work as resident physicians. In other provinces, like Ontario, non-Canadian graduates of international schools do not have to pass the NAC OSCE, but do have to pass the MCCQE1.
- This evidence demonstrates that the current system is not designed to ensure promotion of the best and public safety. Is designed for the purpose of:

  (1) institutional nepotism, the protection by the Faculties of their own graduates and their own prestige;

  (2) improving the efficiency, cost, and distribution of socialized health care by marginalizing Canadians who are graduates from international medical schools so they have little choice but to work in disciplines and regions where graduates of Canadian and American medical schools do not want to work, and

  (3) financial gain from foreigners (visa trainees) paying high fees to the benefit of the Faculties of Medicine and foreign sponsors paying resident physician salaries for the benefit of the Ministry of Health.

3. <u>Graduates of international medical schools are inferior to graduates of Canadian and American medical schools.</u>
    - Studies find that quality of care provided by graduates from international medical schools is equal to (or better than) care provided by graduates of Canadian and American medical schools.

-USA. Tsugawa Y, Jena AB, Orav EJ, Jha AK. Quality of care delivered by general internists in US Hospitals who graduated from foreign versus US medical schools: observational study. *BMJ*. 2017;356(273):1-8. https://www.bmj.com/content/356/bmj.j273; Online at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5415101/?report=printable

-USA. Herbert Wong, Zeynal Karaca, and Teresa B. Gibson. A Quantitative Observational Study of Physician Influence on Hospital Costs. 2018. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing Volume* 55: 1– 12. Online at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6166308/pdf/10.1177_0046958018800906.pdf

-Canada. Ko DT, Austin PC, Chan BT, Tu JV. Quality of care of international and Canadian medical graduates in acute myocardial infarction. *Arch Intern Med.* 2005;165(4):458-463. doi:10.1001/archinte.165.4.458. Online at: https://www.ncbi.nlm.nih.gov/pubmed/?term=15738378

- Hedden, L., Lavernge, M.R., McGrail, K., et al. Trends in Providing Out-of-Office, Urgent After-
Hours, and On-Call Care in British Columbia. *Ann Fam Med.* 2019; 17(2):116-124.
https://doi.org/10.1370/afm.2366. Online at:
http://www.annfammed.org/content/17/2/116.full.pdf

4. Access to residency training, and hence licensing, is merit and competence based with the determination being made at the time of entry to medical school.
    - All medical schools across Canada and the United States set their own admission requirements. Admission requirements to medical school are not uniform. Some weigh heavily on the MCAT. Some place little weight on the MCAT. Similarly, with volunteering. Students get rejected by some schools, accepted by others.
    - Medical school admissions cannot accurately predict each student's development. Some students thrive in medical school. Some do not.
    - It is irrational and poor practice to select the doctors of tomorrow on the basis of "competence for medical practice" when the individual has not taken his/her first medical class, and is not in a position to have or demonstrate critical knowledge and skills important to excellence in medical practice.
    - Competence is most effectively judged at the moment of hire. Ignoring the critical four years where medical knowledge is acquired and medical skills developed is untenable. It is contrary to the public interest to hire graduates from Canadian medical schools as resident physicians who cannot successfully compete on the basis of individual merit against other Canadians, particularly considering that these other Canadians enter the forum with a handicap in the form of bias favouring local graduates and a wide-spread prejudice that international medical

graduates are inferior. It is the responsibility of government to breakdown prejudices, not perpetuate them.

- A fair system of licensing is inclusive. It requires that all seeking licensure have a fair opportunity to demonstrate competence and be licensed. If access to the medical profession and determination of competence takes place at admission to medical school in Canada, immigrant physicians are automatically excluded as they come to Canada having completed medical school.

5. Residency training is a continuum of medical school.

This rationale is inconsistent with the facts.

- Academic education and postgraduate training mandated by a regulatory college to ensure practical experience prior to being licensed for independent practice are two different things.
- Medical school programs and residency programs are not even accredited by the same bodies with medical schools in Canada being accredited by the CACM and LCME and residency training programs by the RCPSC and CFPC.

- The fact that American medical school graduates are treated the same as graduates of Canadian medical schools clearly demonstrates this justification to be false.
- Medical school and residency training are separate steps in the pathway to licensure. First one must graduate high school. Secondly, one must obtain the requisite undergraduate education. Thirdly, one must attend and graduate medical school. Fourthly, one must work as a resident physician to gain the requisite experience for the medical discipline in which licensure will be sought. Fifthly, one must pass the relevant certification examinations of the national colleges. Sixthly, one must be accepted for licensing by the provincial regulatory authority.
- Medical school is academic training delivered pursuant to the legislation which empowers universities to provide education and confer degrees, no different than architecture, engineering, law, and other professional programs. Conversely, postgraduate training in all professions, including medicine, is a requirement imposed by professional regulatory bodies to ensure that professional graduates have practical experience in addition to their academic education/medical degree, that will enable them to practice safely before they are licensed for independent practice. Residency training involves working as a junior physician and culminates in licensing, not a degree as is the case with academic education.
- Medical students are not physicians. They pay tuition fees and are learners of a particular university throughout their education. Conversely, resident physicians are physicians and employees who work under a collective agreement. Resident physicians provide necessary medical services to the public. Students do not. Residents are subject to workers compensation legislation. Students are

not. Vacations, sick leave, and day to day and extraordinary needs of residents are addressed through the employer, not the universities. Although there is an academic component to residency training, continuing education (academic learning) is a requirement throughout a physician's career.

- The educational relationship between university and medical students ends with graduation. A substantial number of students do not train where they obtained their medical degree. For instance, in the 2020 CaRMS Match, 57 out of 159 (31%) University of Ottawa medical graduates matched to University of Ottawa for residency training; 71 out of 192 (37%) McMaster University medical graduates matched to the McMaster University. Many medical graduates move to another province or even to another country for residency training clearly negating the allegation that medical school and residency training are an educational continuum.
- Even the funding is different. The Ministry of Advanced Education funds medical school positions. The Ministry of Health funds residency positions. This is consistent with the fact that the Ministry of Advanced Education funds academic programs and the Ministry of Health funds health care providers.

6. <u>International medical graduates are treated differently based on their place of education, not on the basis of their place of origin or race</u>. There is no breach of human rights if all graduates of international medical schools are treated the same.

    - Immigrants are generally educated in their place of origin. Therefore, this is a distinction without a difference.
    - The legal principle of treating all people of the same class the same is called the "separate but equal" or the "similarly situated" legal doctrine. This was the doctrine relied on historically when Canadian governance embraced "equality" but with an objective to keep Indigenous, Jewish, Coloured, and other undesirable people "in their place".
    - The Supreme Court of Canada decades ago discredited this legal doctrine as an outdated justification for discriminatory treatment. Justice McIntyre stated that this type of reasoning "could be used to justify the Nuremberg laws of Adolf Hitler. Similar treatment was contemplated for all Jews."

7. <u>The system is part of an important policy to control costs and health care delivery makes this discrimination necessary</u>. The government funds only a limited number of residency positions so there is only limited room for international medical graduates.

    - Number of positions available is not rationally connected to protecting one group of Canadians over another.
    - The object of controlling costs and health care delivery can be met without discrimination. Allowing all qualified Canadians to compete for the residency positions available does not interfere with government's control of number of positions it is prepared to fund. In fact, competition based on individual merit is in public interest by selecting the best possible candidate.

8. <u>According to the original AFMC motion: "Since Canadian medical schools are the principal source of the physician workforce for Canada".</u>
    - The system is inconsistent with this rationale. Graduates of American medical schools compete in the full opportunity CMG (Canadian and American Medical Graduate) Stream. In 2020, the Canadian application pool was comprised of 3011 graduates from Canadian schools, 1822 from international schools, and only 60 from American schools. The supply from Europe alone eclipsed the United States with 374 applicants.
- To provide "the main supplier" entry level jobs necessary for licensing has monopolistic overtones. This runs contrary to the purpose of the law related to regulation of the professions. Regulation is to be used for the purpose of ensuring competence and public safety and for no other purpose. Further, democracies are based on competition with legislation and common law generally working to protect against monopolistic powers.

9. <u>All the policies, practices and decisions of the regulatory and related organizations are neutral and based on merit</u>**.**

- This is a false claim when the exclusion of graduates of an international medical school for residencies is so apparent. There is a strongly entrenched belief that policies and practices for selecting residents are neutral and results in the best, most meritorious candidate being selected. In effect, these policies and practices were designed in principle and practice to benefit one population, generally graduates of Canadian and USA medical schools over others.

- In addition, when regulatory and government organizations and universities were established in Canada the dominant group, European origin, Christian, able-bodied, heterosexual, and male designed these systems, and culture and established the organization norms without consideration of other groups (for example, women, Indigenous, non-European Immigrants, LGBTQ2S+, Black, People of Colour, people with disabilities). These differences were never anticipated and are thus not included in the criteria for the design. The intention was that the design would work for everyone and that the organization's policies and practices are neutral. In effect, these policies and practices have had discriminatory effects. Similarly, as selection practices for residencies evolved White men were not only seen as the ideal type of resident, they were often the only group on whom "objective" standards were modeled. As White male residents became the "objective" standard, their identities were taken for granted and seen as neutral.[1]

- While there has been a shift to encompass all those who graduate from Canadian or USA medical schools as the objective standard, barriers continue to exist for members of

[1] Portillo S, Bearfield D, Humphrey N. The Myth of Bureaucratic Neutrality: Institutionalized Inequity in Local Government Hiring. *Review of Public Personnel Administration*. 2020;40(3):516-531. doi:10.1177/0734371X19828431

excluded groups to get into medical schools and fully participate in the health care system.[2]

- Added to this design of omission is the existence of bias and prejudice which also results in exclusion. For example, prejudice against graduates of an international medical school leads dominant group members to blame graduates of international medical schools for their disadvantage. Differences between the dominant group and graduates of international medical schools (linguistic, cultural, religious, and educational) are often exaggerated, so that graduates of international medical schools are portrayed as outsiders worthy of avoidance and exclusion. This prejudice can lead to support for policies that disadvantage immigrant physicians and result in systemic discrimination.[3]

[2] The Future of Admissions in Canada Think Tank (FACTT) Proposed Strategy for Enhancing Admissions. The Association of Faculties of Medicine of Canada. April 22, 2020

[3] National Research Council. (2004). Measuring Racial Discrimination. Panel on Methods for Assessing Discrimination. Rebecca M. Blank, Marilyn Dabady, and Constance F. Citro, Editors. Committee on National Statistics, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press. https://www.nap.edu/read/10887/chapter/7